FINAL REPORT

Milwaukee County Health Care Policy Task Force

General Assistance Medical Program Redesign Recommendations

June 1, 2007

Milwaukee County Department of Health and Human Services

Corey Hoze, Director

DEPARTMENT OF HEALTH & HUMAN SERVICES

Milwaukee County

COREY HOZE • Director

June 5, 2007

Scott Walker, County Executive
Lee Holloway, Chairman, Milwaukee County Board of Supervisors
Milwaukee County
901 North 9th Street
Milwaukee, Wisconsin 53233

Dear County Executive Walker and Chairman Holloway:

On behalf of the Health Care Policy Task Force, we are pleased to present our final report for your review and approval.

Established by County Board Resolution on April 28, 2005, and appointed jointly by the County Executive and County Board Chairman, the Health Care Policy Task Force (HCPTF) has worked diligently over the last eighteen months to develop this comprehensive package of General Assistance Medical Program (GAMP) redesign recommendations.

The report includes two major components. The first component is an enhanced financing approach that will increase the level of Disproportionate Share Hospital funding that can be accessed from the federal government to support uncompensated care for uninsured, indigent Milwaukee County residents. The second component is a redesign of the primary clinic service delivery system to improve quality through improved access to care, chronic disease case management, and specialty care coordination and management.
Both the financing plan and primary clinic redesign represent the input and participation of all key stakeholders and are presented with their full endorsement. The final report was officially and unanimously approved by the HCPTF at its meeting on May 22, 2007.

We believe that implementation of these recommendations will improve the quality and sustainability of GAMP as a critical health care resource for Milwaukee County residents.

Sincerely,

Corey Hoze, Director
Dept. of Health and Human Services

Rob Henken, Director
Dept. of Administrative Services

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Patricia McManus, PhD, Black Health Coalition
Mary Meehan, PhD, Alverno College and Greater Milwaukee Committee

Task Force Conveners: Rob Henken/Corey Hoze, Milwaukee County Department of Health and Human Services

Task Force Staff: John Chianelli, Milwaukee County Health Programs, and Janice Wilberg, PhD., Wilberg Community Planning LLC

Substantial technical assistance was also provided by William Bazan, Wisconsin Hospital Association, and Joy Tapper, Milwaukee Health Partnership.

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Executive Summary

This is the final report of the Health Care Policy Task Force established jointly by Milwaukee County Executive Scott Walker and the Milwaukee County Board of Supervisors to review the General Assistance Medical Program (GAMP) and to provide recommendations to improve the program quality and cost effectiveness.

Ongoing Program Improvements

During the Task Force's tenure and with Task Force members' input, County Health Programs' management team has implemented a set of program improvements including:

- Development of a new application for GAMP services which meets County, State and Federal guidelines;
- Development of a new 72-hour application processing system;
- Implementation of a new online application verification system;
- Design and implementation of a pilot chronic disease management project funded by the Healthier Wisconsin Partnership Program;
- Creation of an online utilization review authorization system;
- Implementation of an online Medicaid (T19) verification system;
- Redesigned web page to improve access and effective utilization by both consumers and providers;
- Development of a member handbook;
- Implementation of a real-time online formulary; and
- Redesign of the State, hospital, and county contracts.

These program improvements have resulted in improved consumer access, more efficient and verified application processes, and a significant level of cost containment.

GAMP Redesign Recommendations

1. Vision, Mission and Guiding Principles

Vision: A County where any medically indigent, low income resident who has an immediate medical need can receive access to timely health care in the most appropriate setting possible.

Mission: To insure fundamental access to appropriate and effective health care for medically indigent, low-income Milwaukee County residents who cannot otherwise obtain it.

Guiding Principles: The General Assistance Medical Program (GAMP) is a general relief program which offers temporary assistance in the form of health care services for low-income, medically indigent Milwaukee County citizens. GAMP is based on the following guiding principles:

a. GAMP has an obligation to provide a user-friendly and accessible enrollment process
b. GAMP and its partners have an obligation to provide the capacity necessary to insure timely access to health care services.
c. Providing health care in community clinics is less expensive and produces superior outcomes than episodic visits to hospital emergency departments.
d. Indigent health care, provided through GAMP and other vehicles, is a scarce community resource that must be managed with great care.
e. Every health care provider – public and private – has a civic obligation to participate in the indigent health care delivery system.
f. The public obligation to provide health care for low-income, medically indigent citizens exists at the local, state and federal levels.
g. Reasonable limits on the utilization of health care are appropriate and necessary to insure the greatest good for the greatest number of Milwaukee County residents.
h. GAMP participants can be effective consumers of health care if provided with good information and access to care management guidance.
i. GAMP must be viewed as a temporary source of health care that can be utilized until an individual obtains a permanent source of health coverage.
j. Those who agree to partner with GAMP have an obligation to work with GAMP to maximize resources from all levels of government to serve GAMP recipients in the most cost-effective, clinically appropriate manner.

2. Financing Plan

A new financing plan was developed collaboratively in September 2006 by Milwaukee County Department of Health and Human Services, County Health Programs, Corporation Counsel, Wisconsin Department of Health and Family Services, Wisconsin Hospital Association, and representatives of the four major Milwaukee County hospital systems. The new plan will allow for continued GAMP funding without the redirection of DSH (Disproportionate Share Hospital) funds from the hospitals to the program. The County now has separate agreements with each respective hospital system to sustain GAMP in its current form with the continued commitment of each hospital system to provide funding in amounts consistent with adopted budgets for GAMP for 2005, 2006, and 2007. A new State Plan Amendment reflecting the new framework was approved by the Centers for Medicare and Medicaid Services on September 27, 2006 and new agreements between CHP and the hospitals were executed shortly thereafter. The new financing plan, because it includes the capability to claim both reimbursed and un-reimbursed DSH expenditures, will potentially allow the hospital systems to draw down additional Federal resources, which could encourage them to invest more resources in primary care for GAMP patients.

3. Primary Clinic Redesign

Fundamental to the long-range viability of GAMP in terms of cost-efficiency and improved outcomes is the redesign of the GAMP health care delivery system. Under the existing model, each component of the system (i.e. primary care clinics, emergency departments, inpatient services, specialty care) operated in virtual isolation from the other components, thus encouraging a single incident care approach that was duplicative, expensive, and service, rather than consumer, focused.

The proposed redesign represents a paradigm shift in the delivery of care to GAMP participants in which primary care clinics which meet quality and capacity criteria will assume responsibility for the integrated health care management of their GAMP clientele. The Redesign includes the following components:

A. *State Plan Amendment*. Seek approval from the State of Wisconsin Department of Health and Family Services to include in the State Plan Amendment the claim for additional federal dollars. This is based on the GAMP hospital systems' ability to secure matching funds in the amount of unreimbursed DSH expenditures. Milwaukee County Department of Health and Human Services, Department of Administrative Services, hospital system partners and State of Wisconsin DHFS will be meeting in the next few months to explore the possibility of making claim to the Federal Government Centers for Medicaid and Medicare Services (CMS) to draw increased federal dollars for uncompensated care provided to GAMP participants.

B. Clinic-based case management that is integrated with primary care. The focus of this service would be to assist patients who have multiple chronic health conditions and/or high utilization of emergency rooms for primary care. One case manager would be allocated to each GAMP Network and be the employee of a designated clinic. Development of seven case manager positions is projected to cost approximately $411,000 based on the existing GAMP pilot grant.

C. *Specialty care coordination and management*. The primary care clinic will continue to be responsible for securing outpatient specialty care. GAMP will establish a referral management process for specialty care. Outpatient specialty care physician recruitment will be the joint responsibility of the system partners. This new system will result in the improved access to high need specialties and address the distribution to as many specialists as possible. Planned distribution of referrals systematically creates improved access and equitable sharing of patients among specialists willing to participate in the initiative. The result of further experience and information of the referral and access system will assist in the determination of the need for development of an enhanced rate for outpatient specialty reimbursement.

D. *Increase outstation application locations to decrease GAMP enrollment in emergency departments*. Currently we have four health care specialists that are processing GAMP applications from hospitals and three health care specialists working in outstation locations. This proposal would allocate five health care specialists at sponsored clinic locations and two in-house processing hospital applications. The goal of this strategy is to create more opportunity for patients to enroll in GAMP in non-emergent situations.

E. *Same day appointment and expanded office hour capacity at the primary care clinics*. Following implementation of the creation of the online referral system for outpatient specialty, primary care clinics would also participate by making a predetermined amount of primary care intake appointment available for their respective hospital system emergency department.

F. *Redesigned retail pharmacy to an open network to improve members' ability to access medication in a manner that is geographically more convenient with access to expanded store hours on evenings and weekends*. County Health Programs Administration will issue a Request for Interest

for providing retail pharmacy services to GAMP and will develop memoranda of understanding with those pharmacies that meet the established criteria.

G. *Deployment of GAMP utilization management to improve the current functions of care coordination*. GAMP would no longer function as gatekeeper for inpatient services as hospitals currently have dedicated resources for this function. GAMP will continue to require hospital pre-certification for the purposes of fulfilling the obligations of eligibility, determining presumptive Medicaid and subrogation activities.

Fiscal Impact of Capacity Building Initiatives

- A main cost in this proposal is the development of a case management model within the primary care clinics to serve individuals who have high-cost chronic illness. While this strategy requires additional financial support, the benefit of increased services would result in improved management of chronic illness and decreased utilization of high cost care. The projected cost estimate for case management is $411,000 based on the existing pilot grant that GAMP received from the Healthier Wisconsin Partnership Program.

- The increased cost of the development of an online referral system for improved management of outpatient specialty care and access to primary care intake appointments for patients being discharged from emergency departments.

Approval of an increased claim of federal DSH (Disproportionate Share Hospital) funds for GAMP hospital system partners could potentially allow the hospital systems to increase their commitment to GAMP in order to fund these initiatives. The main priority of this redesign is to work directly with the State of Wisconsin to secure the full claim. In turn, in light of expanded reimbursement, the hospital systems could elect to fund the above initiatives and offset their current losses.

If the effort to secure additional DSH funding is delayed or unachievable, a second strategy would be to seek approval from the hospital system partners to fund the expansion of case management and the cost associated with the online specialty care referral system from the existing medical services budget of GAMP. The decision to reallocate funds would rest on the following premise: cost savings will be achieved by reinvesting in services like case management and specialty care to insure that patients' primary care needs get met in the most clinically appropriate setting.

All other initiatives in the proposal are cost neutral and do not have an impact on the overall current GAMP budget.

Milwaukee County
Health Care Policy Task Force Final Report

I. Introduction

This is the final report of the Health Care Policy Task Force established jointly by Milwaukee County Executive Scott Walker and the Milwaukee County Board of Supervisors to review the General Assistance Medical Program (GAMP) and to provide recommendations to improve the program quality and cost effectiveness. The report provides a summary of the information considered by the Health Care Policy Task Force (HCPTF) in its deliberations between June 7, 2005 and November 16, 2006, including GAMP history, demographics, service utilization, and critical issues as well as research on national models, financing mechanisms, and service delivery options, and, last, proposed models for financing and service delivery.

II. General Assistance Medical Program History

Historical Perspective

Health care for indigent residents has been part of Milwaukee County government's function since the mid 1800s. Even before statehood, local governments, including Milwaukee County, were required to provide relief to the poor by the Wisconsin Territorial Act of 1838, a responsibility reaffirmed by the 1849 Wisconsin State Statutes which also permitted county governments to become the relief agency for all the municipalities within its boundaries which Milwaukee County quickly did. Part of the responsibility for poor relief included medical care which Milwaukee County provided via contract, e.g. with the Sisters of Charity to provide care for cholera victims in the mid 1850s, through the poor farm system (1852), to the construction of hospitals for the "sick and insane" in 1861. From 1861 forward, the County's operation of its public hospital became its primary health care service delivery vehicle although reimbursement of care by private physicians was also offered as an option to the indigent during the Depression. Until the 1960s, Milwaukee County's public hospital did not treat paying patients; its role as a teaching hospital notwithstanding, the hospital was hard pressed to compete with private hospitals and eventually closed in 1997, two years after the County had transferred ownership to Froedtert Hospital. This move coincided with a change in Wisconsin State Statute that removed the mandate that counties operate general relief medical assistance programs. While the majority of counties discontinued or reduced their programs, Milwaukee County opted to continue its health care program for the uninsured, working with its community partners to design GAMP - the General Assistance Medical Program.

Initial General Assistance Medical Program Design
The General Assistance Medical Program (GAMP) was designed to achieve the following goals:

- *Provision of services in community care settings rather than a hospital setting, which had been the prior history of the program;*
- *Provision of services that focused on primary and preventive care;*
- *Inclusion of a full range of medical service providers rather than a single source of service; and*
- *Self-determination of the individual clients and sensitivity to cultural needs and expectations.*[1]

The initial GAMP model included fifteen (15) community clinics and medical practices and ten (10) hospitals. Emphasis in the model was shifted from the provision of hospital-based care which was likely to be provided in response to acute or emergency situations to the provision of primary and preventive care that would treat health problems and manage chronic diseases so as to avoid more costly hospital episodes. GAMP patients were encouraged to choose their community provider and to seek care from that entity rather than using more expensive hospital-based care. This shift to a community network is one of the most important features of GAMP.

As important as the primary care emphasis of the GAMP model was, the development of an entirely new financing strategy that moved from reliance on a single source, i.e. County property tax levy, to a diversified funding formula which drew in substantial State and Federal resources for the first time. Members of the Health Care Policy Task Force's Financial Management Task Force worked with State Department of Health and Family Services officials, and the Wisconsin Hospital Association to establish an Intergovernmental Transfer Program (ITP). Under ITP, the County transferred County tax levy funds to the State of Wisconsin which then uses those funds as state match to draw down additional Medicaid/DSH (Disproportionate Share Hospital) dollars to support the local provision of indigent health care. The State also contributes GPR (General Public Revenue) to draw down DSH guarantees. In addition, participating hospitals have contributed support for the administration of GAMP and have provided additional, uncompensated care for GAMP patients when annual payment caps have been reached.

Under the 1997 GAMP model, program eligibility and covered services essentially remained the same. The program continued to cover adults, ages 18 to 65, whose incomes fell below the GAMP income standard (Federal Poverty Level), without other insurance or public health program coverage, and presenting with a health problem. Covered services mirrored the Medicaid (T19) service package and included primary care, pharmacy, lab, diagnostic services, home care, durable medical equipment, specialty care, urgent care, emergency department services, and inpatient care. Limited dental services were provided and no behavioral health services. In 2005, individuals enrolled in GAMP were expected to pay an enrollment fee with re-enrollment required at six month intervals.

[1] Milwaukee County Health Programs Division, Department of Health and Human Services, "Healthy People…A Healthy Return on Investment," 2002.

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III. Health Care Policy Task Force

Need for the Health Care Policy Task Force
The Health Care Policy Task Force established on April 28, 2005 is a re-creation of the original Task Force established on January 23, 1997, which conceptualized the General Assistance Medical Program for uninsured residents of Milwaukee County following the closure of Milwaukee County's public hospital in 1995. The new Task Force paralleled the composition of the initial Task Force and carried a similar charge; namely, to develop strategies to improve the operation and cost effectiveness of health care for uninsured people unable to afford other sources of care.

Milwaukee County Board Resolution
Establishing the Health Care Policy Task Force

WHEREAS, on January 23, 1997, the County Board of Supervisors authorized the creation of the Health Care Policy Task Force with a set of objectives including the development of a county-wide plan for the delivery of services to GAMP clients; and

WHEREAS, this 15-member Task Force, jointly approved by the County Executive and the County Board Chair, held a series of meetings in 1997 that culminated in the development of today's General Assistance Medical Program (GAMP), which consists of services and a referral network of community-based clinics linked to hospitals and other medical providers, and which serves approximately 26,000 individuals annually; and

WHEREAS, as GAMP has evolved during the past eight years, a series of significant fiscal and programmatic challenges have emerged, and the Department of Health and Human Services (DHHS) believes that these challenges have now become sufficiently difficult that the re-creation of the Health Care Policy Task Force (HCPTF) is required to assist the Department in addressing them; and

WHEREAS, included among the questions facing GAMP are whether the existing GAMP model is the best health care model to meet the needs of Milwaukee County's uninsured; whether additional strategies must be considered to continue efforts to curb growing GAMP pharmacy costs; whether strategies are needed to control the growing cost of specialty care, including exploration of new management guidelines for approval of specialty care and a possible co-pay for specialty care visits; and whether redesign of the entire GAMP service delivery model is necessary in order to allow the program to continue to draw down available Federal Intergovernmental Transfer Program funds; and

WHEREAS, DHHS is recommending some minor changes to the composition of the HCPTF, which would now consist of 14 members and which again would be jointly appointed by the County Executive and County Board Chairman; and

WHEREAS, as with the previous HCPTF, the new Task Force would be staff by DHHS and CHP staff; now, therefore,

BE IT RESOLVED, that the County Board of Supervisors hereby authorizes the creation of a new Health Care Policy Task Force as outlined above, with members to be jointly appointed by the County Executive and County Board Chairman. (April 28, 2005)

The specific issues giving rise to the decision to seek County Board authorization to recreate the Health Care Policy Task Force included:

- Significant changes in GAMP participants' characteristics, specifically the increasing percentage of uninsured individuals who were employed at the time of GAMP utilization;
- Pharmacy costs projected to exceed the 2005 budgeted amount of $9.8 million by $1.6 million;
- Specialty care costs projected to exceed the 2005 budgeted amount of $5.9 million by $1.0 million;
- Concern regarding the appropriate utilization of hospital emergency department services;
- Emergence of new models of chronic disease management that could result in improved outcomes and lower costs; and
- Need to reexamine the role of primary care clinics relative to coordination of care for GAMP participants.

Health Care Policy Task Force Composition
The Health Care Policy Task Force is comprised of fourteen (14) individuals representing institutions involved in health care for the uninsured including government, providers, and advocates. These individuals were jointly appointed by County Executive Scott Walker and the Milwaukee County Board of Supervisors in April 2005.

Table 1: Health Care Policy Task Force Members

Supervisor Elizabeth Coggs-Jones, Milwaukee County Board of Supervisors
Supervisor Peggy West, Milwaukee County Board of Supervisors
John Bartkowski, DrPH, 16th Street Community Health Center
Bruce Weiss, MD, Managed Health Services
Linda Seemeyer/Rob Henken, Milwaukee County Department of Administration
T. Michael Bolger/Tom Brophy, Medical College of Wisconsin
James Ketterhagen, MD, Medical Society of Milwaukee County
Bevan Baker, CHE, City of Milwaukee Health Department
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Paul Westrick, Columbia St. Mary's Hospital
William Petasnick/Maureen McNally, Froedtert Hospital
Patricia McManus, PhD, Black Health Coalition
Mary Meehan, PhD, Alverno College and Greater Milwaukee Committee

The Task Force was convened by Rob Henken, Director of the Milwaukee County Department of Health and Human Services, and staffed by John Chianelli, Director of Milwaukee County Health Programs, and Janice Wilberg, Ph.D., of Wilberg Community Planning LLC.

Health Care Policy Task Force Mission
DHHS Director, Rob Henken, provided the HCPTF with its charge at the first meeting conducted on June 7, 2005. The purpose of the Task Force was to examine critical issues in GAMP implementation, specifically specialty care, pharmacy, and financing issues, and to make recommendations to the Department of Health and Human Services and to the Milwaukee County Board of Supervisors relative to strategies to improve and enhance the program's operation.

Task Force Operation
The Health Care Policy Task Force met thirteen (13) times between June 7, 2005 and November 16, 2006.[2] Meeting agendas included information presentations, decision items, and public input. Two sub-groups, comprised of HCPTF members and other local experts, were formed to address redesign issues pertaining to financing and services. A third sub-group comprised of executive directors and medical directors of the area's FQHCs (Federally Qualified Health Centers) also met to consider specific service delivery redesign issues.

IV. Research and Policy Analysis

Profile of the GAMP Population
In order to be eligible for GAMP at the time of the formation of the HCPTF, an individual had to be a resident of Milwaukee County, present a valid social security number, meet income criteria, not be a recipient of any other health care program, e.g. Medicaid, and present him/herself for health care. In June of 2005, the GAMP population which totaled 22,285 served during the year was 52.6% male and 47.4% female. Fifty-five percent (55.0%) reported income from employment, a significant change from 1998 when only 30% of the population was employed. The GAMP population was ethnically diverse with 45.4% of the 15,157 individuals served at a point in time during 2004 reporting their ethnic origin as African American, 24.6% reporting Caucasian, 27.8% reporting Hispanic or Latino, 1.2% reporting Native American, and 0.9% reporting Asian heritage.

Table 2: Demographic Comparison: GAMP Population and WPS Comparison Group

Characteristic	*GAMP Population*	*WPS Comparison Group*
Average age	*38.1*	*33.6*
Under age 20	*9%*	*30%*
20 – 34	*33%*	*19%*
35 – 49	*33%*	*26%*
50 – 64	*24%*	*22%*
Male	*51%*	*48%*
Female	*39%*	*52%*
Members per enrollee	*1*	*2.35*

GAMP Population Health Care Utilization
Utilization comparisons between the GAMP population and WPS-covered population at the HCPTF outset in 2005 illustrate two critical factors. First, the GAMP population generally demonstrates greater health care need than the general population. The GAMP population is by definition very low-income, many individuals are homeless or near-homeless, and there is a higher than average incidence of chronic diseases. In other words, much of the GAMP population (by no means all) can be characterized as being 'sicker' than a comparison group of privately insured individuals. The second critical factor is that the utilization of health services by GAMP participants is substantially greater than the WPS comparison group in virtually all categories as shown in Table 3. Inpatient admissions were 73.4% higher for the GAMP population than the WPS comparison group; inpatient days 87.9% higher; visits to the emergency room 271.0% higher. Without reviewing medical charts in detail, it is impossible ascertain what proportion of the GAMP population's higher utilization is indeed attributable to their health status and what proportion is the result of inappropriate utilization of services and/or inefficiencies in the GAMP health care service delivery system.

[2] Specific meeting dates: June 7, 2005, June 21, 2005, July 12, 2005, July 26, 2005, August 9, 2005, August 23, 2005, November 14, 2005, December 13, 2005, January 10, 2006, February 14, 2006,
March 14, 2006, April 24, 2006, and November 16, 2006.

Table 3: Comparison of Health Care Costs GAMP and WPS Populations: 2004

Service	GAMP Population	WPS Comparison	% Difference
Medical (PMPM)[3]	$196.06	$266.71	-26.5%
Drug (PMPM)	$69.75	$45.79	52.3%
Inpatient Admissions[4]	143.01 per 1,000	82.46 per 1,000	73.4%
Inpatient Days	542.29 per 1,000	288.64 per 1,000	87.9%
ER visits	657.74 per 1,000	177.29 per 1,000	271.0%
Office visits	4,544.71 per 1,000	2,576.64 per 1,000	76.4%

GAMP Cost Increases

The increase in the cost of pharmacy services to GAMP recipients was one of the major reasons for re-establishing the Health Care Policy Task Force. Members of the Task Force were presented with information on pharmacy utilization in 2004 when, over the course of the year, there were 29,000 people enrolled in GAMP. Of those, 14,047 (48.4%) received a total of 214,089 prescriptions filled during the year (an average of 15 prescriptions per recipient) resulting in a total pharmacy cost of $10,650,502 for 2004. Co-payments averaged $1.70 per prescription for a total of $387,046. Cost containment measures implemented by County Health Programs in 2004 had a positive impact on rising costs. Overall plan costs dropped 27.2%, the plan cost per member per month dropped from $86.76 to $69.62, a decrease of 19.8%, and co-payment increased from $0 to $387,046. Moreover, the generic dispensing rate increased from 50.6% to 63.0% between 2003 and 2004. In addition, the administration was able to transfer the cost of AIDS/HIV medications to the State of Wisconsin ADAP program (AIDS/HIV Drug Assistance Program) saving Milwaukee County an estimated $500,000 in pharmacy costs annually. While the sum total of these actions was very positive, pharmacy and specialty care costs continued to be an area of concern for the Health Care Policy Task Force.

Table 4: Trends in Pharmacy and Specialty Care Costs: 2001-2005

Year	Pharmacy	Change	Specialty	Change
2001	$7,271,220		$4,053,179	
2002	$11,446,869	57.4%	$6,162,311	52.0%
2003	$14,505,523	26.7%	$5,278,414	-14.3%
2004	10,650,602	-27.2%	$6,800,368	28.8%
2005	$10,600,000	-0.5%	$6,900,000	1.5%

Specialty care was a major focus of the HCPTF particularly the growth in the number of specialists receiving GAMP patients, the limited level of specialty care management built into the existing system, and the shortage of physicians in key specialties.

[3] PMPM = per member per month

[4] 12 month period

Table 5: Number of Specialists Receiving GAMP Payments: 2001-2005

Year	# Specialists[5]	% Change
2001	374	
2002	440	17.6%
2003	516	17.3%
2004	562	8.9%
2005	569	1.2%

Specialty care was identified by program management and the HCPTF as a critical area for reform. The number of specialists receiving GAMP payments increased from 374 in 2001 to 569 in 2005, an increase of 52.1% and this number excludes specialists who were either hospital-based or Medical College of Wisconsin (MCW) physicians. The specialists providing care to GAMP patients were not screened nor were they managed in such a way to insure an available supply of physicians across specialties. Hence, GAMP patients continued to experience difficulties accessing care from key specialties including orthopedics, neurology, OB-GYN, and dermatology. In mid-2005 as the HCPTF was beginning its work, the increasing cost of specialty care was a primary cause of the GAMP financial bind. Specialty care costs negatively affected the other major components of the system, namely primary care and hospital care.

Table 6: Specialty Care as a Percent of Total GAMP Costs: 2001-2005

Year	*Total GAMP Cost*	*Specialty Care Cost*	*Percent*
2001	*$39,511,457*	*$4,053,179*	*10.3%*
2002	*$39,401,580*	*$6,162,311*	*15.6%*
2003	*$39,401,580*	*$5,278,414*	*13.4%*
2004	*$38,401,580*	*$6,800,368*	*17.7%*
2005	*$38,100,412*	*$6,900,000*	*18.1%*

A SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis conducted with the HCPTF provided the following profile of the specialty care situation.

Table 7: SWOT Analysis of Specialty Care

Strengths	*Weaknesses*
• *600 specialists* • *Payment at 100% of T19 rates* • *Year round access*	• *Over-budget 2004 & 2005* • *Lack of some specialties* • *"No shows" for appointments* • *Open benefit package* • *No incentives/disincentives for utilization* • *No coordinated network* • *No certification process* • *Specialty care not include in state calculation for DSH payments*
Opportunities	*Threats*
• *New delivery system*	• *Specialists opting out*

[5] number of specialists receiving payment for services provided to GAMP participants; does not include hospital-based or Medical College of Wisconsin physicians.

• *Structured network* • *Incentives/disincentives to encourage appropriate use* • *Maximize federal DSH calculation*	• *If no change, overall GAMP budget at risk* • *Resource shift to specialty care reduced funds available for hospital reimbursement*

GAMP Financing Structure
Funding for GAMP from its inception in 1997 to 2006 consisted of a blend of Federal, State and County property tax dollars. In 1995, the State of Wisconsin developed a medical relief block grant for Milwaukee County with State reimbursement set at 45% of GAMP medical expenditures up to a maximum of $16.6 million. In 1999, the State established an Intergovernmental Transfer Program (ITP) that captured additional Federal funds and reduced County tax level support for GAMP. This program was expanded in 2002 and again in 2003 for the purpose of increasing funds for medical providers. Under the expanded ITP program the County issued a payment to the Division of Health Care Financing that is used as a match for Federal supplemental payments and disproportionate share payments for hospital services.

GAMP's 2006 budget included $16.6 million in State block grant funds, $16.1 million in ITP funds, and $12.1 million in County property tax levy. The County's property tax levy contribution included an ITP of $6.8 million which was matched with Federal funds of $9.3 million for the total ITP payment of $16.1 million. The 2006 budget also contains a $2.1 million contribution from GAMP hospital system partners for various GAMP administration costs.

V. GAMP Redesign Recommendations

The GAMP Redesign Recommendations are organized in three sections: 1) Vision, Mission and Guiding Principles; 2) Financing Plan; and 3) Primary Clinic Redesign.

1. Vision, Mission and Guiding Principles

The following vision, mission, and guiding principles were reviewed and endorsed by the Health Care Policy Task Force as the foundation for the GAMP Redesign Plan.

Vision: A county where any medically indigent, low-income resident who has an immediate medical need can receive access to timely health care in the most appropriate setting possible.

Mission: To insure fundamental access to appropriate and effective health care for low-income, medically indigent Milwaukee County residents who cannot otherwise obtain it.

Guiding Principles: The General Assistance Medical Program (GAMP) is a general relief program which offers temporary assistance in the form of health care services for low-income, medically indigent Milwaukee County citizens. GAMP is based on the following guiding principles:

a. GAMP has an obligation to provide a user-friendly and accessible enrollment process.
b. GAMP and its partners have an obligation to provide the capacity necessary to insure timely access to health care services.
c. Providing health care in community clinics is less expensive and produces superior outcomes than episodic visits to hospital emergency departments.
d. Indigent health care, provided through GAMP and other vehicles, is a scarce community resource that must be managed with great care.
e. Every health care provider – public and private – has a civic obligation to participate in the indigent health care delivery system.

f. The public obligation to provide health care for low-income, medically indigent citizens exists at the local, state and federal levels.
g. Reasonable limits on the utilization of health care are appropriate and necessary to insure the greatest good for the greatest number of Milwaukee County residents.
h. GAMP participants can be effective consumers of health care if provided with good information and access to care management guidance.
i. GAMP must be viewed as a temporary source of health care that can be utilized until an individual obtains a permanent source of health coverage.
j. Those who agree to partner with GAMP have an obligation to work with GAMP to maximize resources from all levels of government to serve GAMP recipients in the most cost-effective, clinically appropriate manner.

2. Financing Plan

The Health Care Policy Task Force reviewed GAMP financing improvements that focused on maximizing the availability of DSH payments to support care for the uninsured in Milwaukee County. The financing proposal was the result of extensive discussion among the CEOs and Financial Officers of the local hospital systems participating in GAMP; namely, Aurora Health Care, Columbia/St. Mary's, Wheaton Franciscan, and Froedtert/Medical College of Wisconsin, as well as extensive discussions with Wisconsin Department of Health and Family Services Division of Health Care Financing officials and, through the State, with CMS officials (U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, the entity charged with the review and approval of each state's plan for DSH allocation).

DSH Funding Agreement: Under Section 49 of the Wisconsin Statutes and the guidelines developed by the Division of Health Care Financing and previously approved by CMS, the combined $32.7 million in State and Federal funding was sent to participating hospitals that served a disproportionate share of low-income uninsured patients. Under previous State plans, these dollars were then transferred to Milwaukee County Health Programs (CHP) per a provision in the medical service agreements maintained by CHP in the operation of GAMP with its hospital partners.

In considering the most recent State Plan Amendment submitted by Wisconsin DHFS, CMS indicated that it would no longer approve of a contractually mandated transfer of the DSH (Disproportionate Share Hospital) funds from the hospitals to Milwaukee County Health Programs for the operation of GAMP. However, both DHFS and CMS indicated that it would be allowable for CHP to maintain separate agreements with the hospitals that established their desire and intent to provide funding for GAMP in light of the hospitals strong interest in providing comprehensive health care services as an alternative to emergency room care for indigent individuals. Furthermore, it became evident that the DSH claim should be expanded to reflect both reimbursed and un-reimbursed expenditures made by DSH hospitals on GAMP recipients as opposed to just expenditures made by GAMP on hospital-based care.

Milwaukee County DHHS, CHP, and Corporation Counsel met with DHFS, representatives from the four major Milwaukee County hospital systems, and the Wisconsin Hospital Association during September 2006 to develop a new framework that would allow for continued GAMP funding without the redirection of DSH funds from the hospitals to the program. The County now has separate agreements with each respective hospital system to sustain GAMP in its current form and that dictated the continued commitment of the hospital systems to provide funding in amounts consistent with GAMP's adopted budgets for 2005, 2006, and 2007. A new State Plan Amendment reflecting the new framework was approved by CMS on September 27, 2006, and new agreements between CHP and the hospitals were executed shortly thereafter.

The long-term impacts of the new CMS requirements are still under review by DHHS and its GAMP partners. Clearly the ability to claim Federal dollars based on both reimbursed and un-reimbursed DSH hospital expenditures for services to GAMP recipients could create significant new opportunities to restructure GAMP funding to provide greater emphasis on primary care and possibly draw down additional Federal resources.

3. Primary Clinic Redesign

The services subcommittee of the Health Care Policy Task Force along with the directors and medical directors of Milwaukee's Federally Qualified Health Centers (FQHC) developed a new, more focused and efficient health care delivery model for the General Assistance Medical Program. The charge of this committee was to focus on several key elements that included capacity building initiatives such as case management, expanded community intake, clinic-based specialty care panel and urgent care.

This proposal builds on the success of the General Assistance Medical Program and introduces several innovative principles improving the delivery of services to individuals enrolled in the program. The following proposal outlines the delivery of primary care clinic-based services utilizing an integrated health management approach. Once approved, this proposal's content shall become the contractual language binding the agreement between Milwaukee County and the contracted Primary Care Clinics.

Paradigm change for the delivery of primary care services
The proposed redesign represents a paradigm shift in the delivery of primary care to GAMP participants. Recognizing that GAMP is a program intended to provide temporary health care assistance to low-income, uninsured Milwaukee County residents, the Health Care Policy Task Force services subcommittee and clinic leadership understand the improved health outcomes and cost savings that could result from more integrated health management. In this paradigm shift, primary care clinics which meet quality and capacity criteria will assume responsibility for the integrated health care management of their GAMP clientele. The key components of the new model are described below.

Primary Care Utilizing an Integrated Health Management Approach
- The philosophy emphasizes cross-program, whole-person integrated health management, rather than a one person, one illness, one visit approach.
- Upon enrollment, clients must select the clinic of their choice from the network of GAMP clinics.
- Primary care clinics will be open to enrollment until the identified contract maximum census is obtained.
- The primary care clinics will have the ability to sponsor GAMP intake and renewal by providing coordination assistance and physical space.
- The primary care clinics will have the ability to support and provide case management services on site with the capacity to also serve individuals in their home environment. The focus of this service is chronic disease management.
- Primary care clinics will function as the medical home for GAMP participants and coordinate all primary care, specialty care, and include all aspects of individuals' care plans.
- The new model includes the establishment of a transdisciplinary care approach that promotes an online referral system to improve coordination and access to outpatient specialty care.

Criteria for Primary Care Clinic Participation
- Provide the opportunity for patients to access primary care after hours, including evening and weekend hours.
- Internal process for the development of quality assurance, outcomes monitoring, and professional credentialing.

- An established memorandum of agreement with a GAMP affiliated hospital system for inpatient admission and treatment, access to diagnostic evaluation, and surgery which includes active privileges or an agreement to use hospital staff to manage any inpatient or emergency care.
- Ability to provide services to individuals who have accessibility issues such as physical, culturally sensitive care, linguistic special needs.
- Qualified provider under the Medicare/Medicaid program.
- Compliance with the GAMP Utilization Management Department guidelines established in the GAMP policy and procedure manual.
- Compliance with third-party Medical Assistance recoupment process in accordance with policies and procedures established by the GAMP Claims Management Department.
- Participation in the new online referral system and active participation of outpatient specialist recruitment.
- Electronic claiming capability with the contracted third-party claims administrator (currently Wisconsin Physician Services).
- Presence of an internal policy and procedure for grievance of client complaints.
- Other Milwaukee County expectations including, but not limited to, the following:
  - Civil Rights compliance
  - Non-discrimination, equal opportunity employment
  - Proof of financial responsibility, i.e. insurance, audit
  - Health information compliance
  - Access to all financial and clinical/medical records
- Clinics must be able to maintain minimal GAMP capacity of 250 participants and be willing to accept admissions from GAMP.

Redesign Elements
Following are specific recommendations regarding the changes necessary to build the capacity of eligible primary care clinics to assume greater responsibility for integrated health management under the GAMP Primary Clinic Redesign.

A. Redesign of the enrollment and renewal process.

Key Elements:
- GAMP members must enroll and renew applications at the primary care location rather than the hospital emergency departments.
- Increase enrollment outstation locations to address the GAMP enrollment access issue, each location would operate an outstation location similar to the outstation location run at MLK. This could also include opening a location at the Coggs Center. The premise being, offering more opportunity to enroll in GAMP during non-emergent situations would decrease the amount of emergency department utilization for non-emergency conditions.
- This methodology would also create improved continuous care as the patient could enroll in GAMP at the same location that could be their medical home.

Primary Care Clinic shall:

1. Provide space and support the function of an operation of an intake and renewal site. This would include the ability for GAMP to advertise the location as a site where new applicants can become enrolled in GAMP.
2. Provide reception services to those appearing for application on scheduled mornings.
3. Collaborate with GAMP Health Care Specialists in order to manage the waiting room.

Milwaukee County shall:

1. Provide a Health Care Specialist to enroll applicants on scheduled days.
2. Collaborate with the clinic receptionist to ensure that individuals are being processed in a timely manor.
3. Coordinate with the receptionist to schedule first or return appointments with the applicant/member's primary physician.

B. Creation of chronic disease management services-Case Management

Key Elements:

- Create case management capacity in each of the clinics. The purpose of this case management would be to assist enrollees in accessing care, programs and entitlement services needed to sustain health in the community.
- The focus on management of long-term health conditions by utilizing self-health management options in the community would create better health outcomes for clients.
- Another focus would be to shift clients' use to more clinically appropriate care, e.g. limiting use of emergency rooms for primary care treatment.
- This form of case management is targeted to clinical disease management rather than episodic care coordination or utilization review.

Primary Care Clinic shall:

1. Retain, train and employ one case manager who will have the responsibility for the ongoing management of individuals referred by the primary care physician.
2. Target individuals for case management who are enrolled in the clinic and unable to manage a chronic illness effectively as identified through the assessment of the primary care physician.
3. Establish the following criteria for the provision of case management:
   a. Individual who has a chronic health condition such as diabetes, asthma, cardiovascular disease (hypertension or hyperlipidemia); and
   b. With repeated visits to the primary care physician is unable to self manage his/her condition, requiring repeated visits to the emergency room or requiring repeated hospitalizations; and
   c. If the management of this condition is not supported with additional services the individual is at risk for repeated emergency and/or inpatient episodes; and
   d. With additional services the individual will be likely to establish control of the prevailing symptoms.
4. The case manager shall, upon referral, develop an individual assessment and establish a plan of care that addresses identified problems.
5. The plan of care shall outline the frequency of contacts, duration of case management services and the location where the services shall be provided.
6. The case management episode would be consistent with the individual's GAMP enrollment segment and require prior authorization at time of renewal.
7. Case management services should include the following services:
   a. is defined as a clinical service in which individual client care decisions are made throughout a client's relationship with both formal and informal care giving systems to assure the client's desires are known and his/her goals are achieved,

needed services are provided, and he/she is able to manage health conditions and maintain proper control of health issues.

b. Case managers shall be trained professionals and paraprofessionals with core competencies in symptomatology, understanding side effects of medications/treatment/services, planning in multidisciplinary approaches, teaching living skills, use of community resources, support, advocacy, listening and cultural competencies.

c. Case management/client activities should include:
   1) Designing an individual plan of care to meet the needs of the client;
   2) Service referral, linkage and brokering;
   3) Skills training;
   4) Communication and coordination with other caregivers;
   5) Listening and supporting clients' needs;
   6) Advocating;
   7) Obtaining needed benefits such as participation in patient drug assistance programs, food stamps and/or Medicaid;
   8) Assisting the client in coordination of all providers involved in treatment; and
   9) Helping the client articulate and achieve personal goals, including but not limited to access to specialty care appointments.

d. Case management services are provided throughout the client's care whenever assistance is needed and at regular predetermined intervals, i.e. daily, weekly, monthly, every 90 days, based on the client's individual needs. This will include whenever the client's condition requires use of other systems' services such as hospitalization.

Milwaukee County shall:

1. Provide utilization management to authorize continuation of case management at the time of renewal should there be a need for continued case management services beyond the six month segment.

C. Specialty Care Model

Key Elements:

- Creation of an outpatient specialty-care referral system that provides improved access, flexibility and control by the primary care provider. The goal is to improve the overall management of individuals with chronic disease and to reduce the current high utilization of inpatient and emergency room for urgent and emergent care. This model would reduce duplication and repeated, unnecessary procedures and testing.
- The primary care clinic will continue to be responsible for securing outpatient specialty care.
- GAMP will establish a referral management process for specialty care.
- Outpatient specialty care physician recruitment will be the joint responsibility of the system partners.
- This new system will result in the improved access to high need specialties and address the distribution to as many specialists as possible.
- Planned distribution of referrals systematically creates improved access and equitable sharing of patients among specialists willing to participate in the initiative.
- The result of further experience and information of the referral and access system will assist in the determination of the need for development of an enhanced rate for outpatient specialty reimbursement.

Primary Care Clinic shall:

1. Establish policies and procedures that govern the new referral system methodology and work with GAMP to monitor system effectiveness.
2. Coordinate with other clinic partners when volume and type of specialty care elements cannot be arranged.
3. Actively participate in the recruitment of outpatient specialists to participate in the online referral system.
4. Comply with all policies and procedures set forth by the GAMP Utilization Review Department.
5. All other outpatient and certain inpatient specialist care will be provided and reimbursed through the current fee for service network.

Milwaukee County shall:

1. Establish an online referral system for the ongoing management of outpatient specialty care.
2. Participate with the system partners in the recruitment of outpatient specialty care providers to participate in the online referral system.

D. Plan for Clinic Geographic Coverage

Key Elements:

- Primary care clinics must be located in the medically underserved area of Milwaukee, defined federally.
- Hospital system/clinic affiliations need to take in account geographical proximity.

Primary Care Clinic shall:

- Provide access to services in the most geographically accessible location for the individuals served in the program.

Milwaukee County shall:

- To the extent possible, ensure that clinics are geographically dispersed across the county.

E. Clinical Management Services

Key Elements:

- Development of a clinical oversight committee comprised of provider representatives to work directly with GAMP Administration on clinical issues surrounding the delivery of health care.
- Consumers would be required to choose their medical home and primary provider annually creating improved coordination of care with a focus on long term management for those members continually enrolled in GAMP. Consumers would no longer switch medical homes every six months.
- The Primary Care Clinic would have the primary role of coordinating the patient's care including specialty care, medications and procedures.
- This role would include those functions that are necessary to achieve the overall medical management of a consumers care. Utilization management would be integrated for greater efficiency in oversight and management of authorizations and pre-certifications.

Primary Care Clinic shall:

1. Provide primary care providers (physicians and nurse practitioners) for the assessment, diagnosis and treatment that meet a client's medical/health care needs.
2. Provide access to care appointments through a scheduling procedure.
3. Document proof of an active medical license for each affiliated physician and credentials commensurate with their clinical practice.
4. Embrace medical best practice.
5. Establish internal quality assurance and clinical outcome protocols that are reportable to Milwaukee County annually. Outcome reporting would be based on the same reporting requirements the clinic has mandated from other governing entities.

Milwaukee County shall:

1. Review outcome and quality assurance data and provide analysis.
2. Monitor compliance with all criteria in this contract.
3. Provide utilization management through a paperless electronic system.

F. Same Day Appointments and Expanded Office Hour Capacity

Key Elements:

- Primary care clinics shall provide flexible scheduling and expanded office hours.
- This strategy would provide patients an alternative opportunity to seek urgent and routine care from their medical home rather than hospital emergency department.
- Participate in the online referral system by posting available intake appointments for utilization by their respective hospital emergency department.

Primary Care Clinic shall:

1. When possible, primary care clinics will offer same day appointment to individuals who have urgent need. Access to same day appointments will impact the potential for patients to use the emergency room for primary care.
2. Primary care clinics shall provide patients with the opportunity for expanded office hour appointments. This could be achieved by a few evening or weekend appointment schedules.
3. Primary care clinic shall receive triaged patients from the emergency department through participation in the online referral system.

Milwaukee County shall:

1. Maintain the proper codes in the claiming system to ensure reimbursement of expanded office hour appointments.

Recommendations for Capacity Building

The proposed redesign represents a paradigm shift in the delivery of care to GAMP participants in which primary care clinics that meet quality and capacity criteria will assume responsibility for the integrated health care management of their GAMP clientele. The Redesign includes the following components:

1. *State Plan Amendment*. Seek approval from the State of Wisconsin Department of Health and Family Services to include in the State Plan Amendment the claim for additional federal dollars. This is based on the GAMP hospital systems' ability to secure matching funds in the amount of unreimbursed DSH expenditures. Milwaukee County Department of Health and Human Services, Department of Administrative Services, hospital system partners and State of Wisconsin DHFS will be meeting in the next few months to explore the possibility of making claim to the Federal Government Centers for Medicaid and Medicare Services (CMS) to draw increased federal dollars for uncompensated care provided to GAMP enrollees.

2. *Clinic-based case management that is integrated with primary care.* The focus of this service would be to assist patients who have multiple chronic health conditions and/or high utilization of emergency room for primary care. One case manager would be allocated to each GAMP Network and be the employee of a designated clinic. Development of seven case manager positions is projected to cost approximately $411,000 based on the existing GAMP pilot grant.

3. *Specialty care coordination and management*. The primary care clinic will continue to be responsible for securing outpatient specialty care. GAMP will establish a referral management process for specialty care. Outpatient specialty care physician recruitment will be the joint responsibility of the system partners. This new system will result in the improved access to high need specialties and address the distribution to as many specialists as possible. Planned distribution of referrals systematically creates improved access and equitable sharing of patients among specialists willing to participate in the initiative. The result of further experience and information of the referral and access system will assist in the determination of the need for development of an enhanced rate for outpatient specialty reimbursement.

4. *Redesign retail pharmacy to an open network as a result of the change in the federal claiming methodology achieved in fall of 2006.* The open pharmacy network will potentially improve members' ability to access medication. This is achieved by having more geographically convenient access and expanded store hours on evenings/weekends. This new contracting approach will create competition that could result in cost savings. County Health Programs Administration will issue a Request for Interest for providing retail pharmacy services to GAMP and will develop memoranda of understanding with those pharmacies that can fulfill the established criteria.

5. *Increase outstation application locations to decrease GAMP enrollment in emergency departments*. Currently we have four health care specialists that are processing GAMP applications from hospitals and three health care specialists working in outstation locations. This proposal would allocate five health care specialists at sponsored clinic locations and two in-house processing hospital applications. The goal of this strategy is to create more opportunity for patients to enroll in GAMP in non-emergent situations.

6. *Same day appointment and expanded office hour capacity at the primary care clinics.* This would include posting intake appointment on the new online referral system from the hospital emergency departments.

7. *GAMP utilization management will redeploy resources to improve the current functions of care coordination*. GAMP would no longer function as gatekeeper for inpatient services as hospitals currently have dedicated resources for this function. GAMP will continue to require hospital precertification for the purposes of fulfilling the obligations of eligibility, determining presumptive Medicaid and subrogation activities.

Fiscal Impact of Capacity Building Initiatives

- A main cost in this proposal is the development of a case management model within the primary care clinics to serve individuals who have high-cost chronic illness. While this strategy requires additional financial support, the benefit of increased services could result in improved management of chronic illness and decreased utilization of high cost care especially emergency department services and specialty care. The projected cost estimate for case management is $411,000 and is based on the existing pilot grant that GAMP received from the Healthier Wisconsin Partnership Program.

- The increased cost of the development of an online referral system for improved management of outpatient specialty care and access to primary care intake appointments for patients being discharged from emergency departments.

Approval of an increased claim of federal DSH (Disproportionate Share Hospital) funds for GAMP hospital system partners could potentially allow the hospital systems to increase their commitment to GAMP in order to fund these initiatives. The main priority of this redesign is to work directly with the State of Wisconsin to secure the full claim. In turn, in light of expanded reimbursement, the hospital systems could elect to fund the above initiatives and offset their current losses.

If the effort to secure additional DSH funding is delayed or unachievable, a second strategy would be to seek approval from the hospital system partners to fund the expansion of case management and increased reimbursement rates from the existing medical services budget of GAMP. The decision to reallocate funds would rest on the following premise: cost savings will be achieved by reinvesting in services like case management and specialty care to insure that patients' primary care needs get met in the most clinically appropriate setting.

All other initiatives in the capacity building proposal are cost neutral and do not have an impact on the overall current GAMP budget.

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Health Care Policy Task Force Final Report

Appendix

Indigent Health Care Models – Literature Review

There is a great deal of published information about the challenge of providing health care to uninsured, indigent people. The appendix presents key findings from a review of the literature that assisted members of the Health Care Policy Task Force in considering alternative directions for Milwaukee County's General Assistance Medical Program (GAMP). The report is organized into the following sections:

- National Perspective: General Assistance Medical Programs
- Disproportionate Share (DSH) Program
- Innovations in DSH Financing for Indigent Care
- State Medicaid Waiver Projects
- States' Waiver Innovations
- Local (Metropolitan Level) Indigent Care Innovations
- Emerging Themes

National Perspective: General Assistance Medical Programs

The most recent national inventory of General Assistance Medical Programs was conducted by the Urban Institute in 1999 as part of a broader examination of General Assistance (GA) programs. [6] General Assistance is defined by the Urban Institute as:

> "*…cash and in-kind assistance programs financed and administered entirely by the state, county, or locality in which they operate…designed to meet the short-term or ongoing needs of low-income persons ineligible for federally funded cash assistance such as Temporary Assistance for Needy Families (TANF) or Supplemental Security Income.*"

In 1999, thirty-five states had some form of General Assistance. A state was identified as having General Assistance (GA) if it had a statewide program, administered GA through counties, or provided funding or other support for individual counties' General Assistance programs. In addition, there were seven states that did not operate a GA program but had one or more counties which did so independently; another ten states had no GA program at either the state or local levels.[7] Following is a table showing the distribution of states relative to their General Assistance programming.

[6] L. Jerome Gallagher, Cori E. Uccello, Alicia B. Pierce, Erin B. Reidy, "State General Assistance Programs 1998," The Urban Institute, 1999.

[7] Ibid, pp. 97-104.

Appendix Table 1: States' Involvement in General Assistance Programs

Type of General Assistance Involvement	*States*
State-operated or supported GA Program	*Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, and Wisconsin*
No state program; but 1 or more individual counties have GA	*Florida, Georgia, Kentucky, Montana, North Carolina, and North Dakota*
No state or county GA programs	*Alabama, Arkansas, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, Texas, West Virginia, and Wyoming*

Nearly all (94%) of the thirty-five states that operate or support General Assistance programs also provide medical assistance. Of the thirty-three states that provide medical assistance, five states incorporate GA recipients into their T19 or T19 waiver programs; twenty-six states and two individual counties provide medical assistance through other, non-T19 means.

In many GA states (including Wisconsin), the GA Medical Assistance program attracted a broader constituency than the GA cash assistance program; in other words, more people accessed GA Medical Assistance than accessed the cash assistance program particularly as cash assistance programs have been replaced by TANF, Food Stamp Employment and Training programs, and Supplemental Security Income (SSI).

Non-General Assistance states often have other forms of medical assistance for indigent people, including T19 waiver programs, hospital charity care, and services offered through the nonprofit sector. Texas and Tennessee, both states without GA or GA Medical programs, provide medical assistance for low-income individuals, similar to that provided by GA Medical programs.

Disproportionate Share (DSH) Program

Medicaid Disproportionate Share Hospital Funds, also known as DSH, is the country's primary source of funding for uncompensated (indigent) health care. Most DSH funds are used to reimburse hospitals for uncompensated care provided to indigent people. The DSH program, originally enacted in the early 1980's and further enhanced in the 1990's, is at the base of very complex financing systems that involve provider taxes, donation programs, and intergovernmental transfers. DSH payments are made to hospitals which serve a "disproportionate share" of indigent people; those payments then generate federal matching funds.

Increasingly, states are looking at new ways to manage DSH, along with Inter-Governmental Transfer (IGT) funds, as a way to reduce the high cost of indigent health care by increasing access to primary and preventive care. However, this approach carries certain risks that as DSH funds are moved to provide non-hospital based services, the benefits of earlier intervention will not outweigh the loss of DSH funding.

A recent study published by the National Health Policy Forum found great variation in states' use of DSH payments to support indigent care. Because of the program's rapid growth, Congress tightened the program in the 1990's, thereby creating an almost permanently unequal system with some states drawing down substantial DSH payments while other states, newer to the system, are able to generate very little.

In 2001, thirty-two states generated $6.2 billion in DSH "gains", ranging from a high of $1.0 billion in California to a low of $0.1 million in Wyoming. Wisconsin, at $6.6 million, ranked seventh lowest among the thirty-two states.[8] The DSH system is so complex that few people, even in health care, fully understand the nuances of this important funding source. Robert Mechanic concluded his comprehensive review of DSH programs by stating:

> *DSH is a critical source of financing for health care provided to low-income and uninsured patients; however, it continues to be a focal point in the federal-state battle over Medicaid financing. The DSH program is complex and lacks good reporting systems and financial controls. Controversy over states' use of DSH programs to enhance federal Medicaid matching funds sometimes overshadows the importance of directing necessary funding to institutions that serve low-income patients. Furthermore, growth of supplemental payment programs like DSH that are financed by provider taxes and IGT's greatly complicates Medicaid program evaluation and oversight. In the absence of a viable plan to broadly expand health insurance coverage, support for providers that serve low-income patients will become increasingly critical. It is essential that states and the federal government come together to design funding strategies that equitably and effectively strengthen the nation's health care safety net.*[9]

[8] Mechanic, Robert E., "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments, National Health Policy Forum, The George Washington University, Washington, D.C. September 14, 2004.
[9] Mechanic, p. 17.

Appendix Table 2: DSH Payments and DSH as a Share of Total Medicaid Expenditures: FY 2001 (dollars in millions)[10]

State	Total DSH Payments	DSH as Share of Total Medicaid Expenditures
Total	$10,745.1	7.6%
Alabama	367.0	12.3
Alaska	7.8	2.2
California	1,991.3	7.5
Connecticut	320.1	8.9
District of Columbia	45.7	5.5
Florida	361.4	3.7
Georgia	418.0	7.9
Idaho	1.4	1.3
Indiana	299.0	16.9
Iowa	13.6	0.8
Kentucky	191.1	5.6
Louisiana	870.2	20.2
Maryland	80.9	1.8
Massachusetts	485.3	6.6
Michigan	435.3	5.5
Mississippi	181.4	7.1
Missouri	459.9	9.2
Nebraska	10.2	0.1
New Jersey	1,154.0	15.2
North Dakota	1.0	0.2
Ohio	618.7	7.2
Oklahoma	23.3	1.1
Oregon	14.4	1.0
South Carolina	372.0	12.0
Texas	1,369.0	10.1
Utah	3.8	0.4
Vermont	24.5	4.1
Virginia	187.9	7.3
Washington	346.9	5.7
West Virginia	78.8	5.7
Wisconsin	11.2	0.3
Wyoming	0.1	0.1

[10] Source: Urban Institute Survey of DSH Programs, 2002 in Coughlin, Teresa A., Brian K. Bruen and Jennifer King. "States' Use of Medicaid UPL and DSH Financing Mechanisms." *Health Affairs* 23 (2), 245-257.

A review of health care policy and financing trends in Wisconsin conducted by the Urban Institute concluded that, despite Wisconsin's pattern of health care innovation relative to managed care, the use of SCHIP and Medicaid waivers to create BadgerCare, and the development of community-based long term care options using the Medicaid IGT program, the state had made minimal use of DSH to support uncompensated care.

> *Wisconsin's Medicaid program has made little use of the disproportionate share hospital (DSH) payments either to increase federal revenues or to provide aid to hospitals with large amounts of uncompensated care. The state has, however, made heavy use of supplemental payments, which are very much like DSH.*[11]

Innovations in DSH Financing for Indigent Care

Six model programs, including Milwaukee County's GAMP, are profiled in a Commonwealth Fund report, "Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds."[12] Following is a table showing the highlights of each of these models.

Appendix Table 3: Uncompensated Care Model Programs

Location	*Program*	*Innovation*
Milwaukee County, Wisconsin	*General Assistance Medical Program (GAMP)*	*Community-based primary care model with "unique and complex" funding stream: state block grant, county tax levy, intergovernmental transfers, Medicaid DSH; participation of all local hospitals, utilization management, and capped budget (total $38.4 M in FY 2003)*
Georgia	*Georgia Indigent Care Trust Fund*	*Statewide program funds hospital and primary care, funding combined with intergovernmental transfers from local governments, nursing home provider fees, ambulance licensure fees, Certificate of Needs noncompliance penalties, and breast cancer license plate fees (total $731.4 M in FY 2004)*
Massachusetts	*Massachusetts Uncompensated Care Pool*	*Reimbursement program for hospitals and community health centers serving low-income uninsured; financed with assessments on hospitals and insurers, intergovernmental transfers, state funding, tobacco settlement funds, and DSH; portion of charity care returned to health providers to promote primary care; emphasis on demonstration projects to improve health outcomes.*

[11] Bruen, Brian K. and Joshua M. Wiener, "Recent Changes in Health Policy for Low-Income People in Wisconsin," Assessing the New Federalism, The Urban Institute, State Update No. 25, March 2002, p. 2.
[12] Silow-Carroll, Sharon and Tanya Alteras, "Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds," Economic and Social Research Institute, The Commonwealth Fund, October 2004.

Muskegon County, Michigan	*Access Health*	*Subsidized comprehensive health coverage for uninsured workers in small and medium-size companies; 3-way cost share: employer (30%), employee (30%), and community (40%). Community share matched with DSH; state seeking additional DSH funding to support program expansion in Muskegon and elsewhere.*
Maine	*MaineCare*	*Medicaid expansion for adults without children financed with unused DSH funds and tobacco tax revenue; primary care-case management approach with full Medicaid benefit package.*
Project being developed		
Louisiana	*LA Choice*	*State seeking waiver to expand Medicaid coverage, including allocation of DSH dollars to subsidize insurance premiums for low-income workers*

State Medicaid Waiver Projects

Two types of Medicaid waivers are germane to GAMP: 1) Medicaid Section 1115 Waiver; and 2) HIFA Section 1115 Waiver.

Medicaid Section 1115 Waiver: The Medicaid Section 1115 waiver affords states the flexibility to try new approaches to providing health care to low income people. The Robert Wood Johnson Foundation provides this synopsis of Section 1115 waivers:

> *Section 1115 of the Social Security Act grants the Secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid of SCHIP for the purpose of conducting pilot, experimental or demonstration projects which are "likely to promote the objectives" of the program. Section 1115 demonstration waivers allow states to change provisions of their Medicaid or SCHIP programs, including: eligibility requirements; the scope of services available; the freedom to choose a provider; a provider's choice to participate in a plan; the method of reimbursing providers; and the statewide application of the program. Demonstration waivers are granted for research purposes, to test a program improvement, or investigate an issue of interest to CMS. Projects must usually include a formal research or experimental methodology and provide for an independent evaluation. Most projects run for a limited time, no more than 5 years, and are usually not renewable.*[13]

As of March 2004, fifteen states and the District of Columbia had obtained Section 1115 waivers. Of these, nine states had obtained waivers to expand Medicaid coverage to uninsured, very low income adults without children. Those states include Arizona, Delaware, Hawaii, Massachusetts, New York, Oregon, Tennessee, Utah, and the District of Columbia. Wisconsin has a Section 1115 waiver for BadgerCare to allow the extension of Medicaid services to uninsured children and parents with incomes below 185% of the Federal Poverty Level.[14]

[13] Medicaid Section 1115 Waiver, State Coverage Matrix, State Coverage Initiatives, The Robert Wood Johnson Foundation, Academy Health, Washington, D.C.
[14] Ibid.

Appendix Table 4: States with Medicaid Section 1115 Waivers for Uninsured Single Adults

State	*Program*	*Eligible Population*[15]	*Services*
Arizona	*Healthy Arizona: Arizona Health Care Cost Containment System*	*Adults under 65 with incomes below 100% of FPL*	*Inpatient & outpatient hospital services, emergency room care, physician services, outpatient health, lab, X-ray, pharmacy, behavioral health*
Delaware	*Diamond State Health Plan*	*Adults under 65 with incomes below 100% of FPL*	*Basic medical and mental health services; GA Health First provides case management services to adults on GA*
District of Columbia	*District of Columbia 1115 for Childless Adults*	*Adults, ages 50 to 64 with incomes below 50% of FPL*	*Medicaid package: inpatient, outpatient, therapies, pharmacy, and transportation*
Hawaii	*Hawaii QUEST*	*GA population; adults under 65 with incomes below 100% of FPL; QUEST-Net covers people who lost Medicaid eligibility up to 300% FPL*	*QUEST offers Medicaid package, emphasizing preventive care; QUEST-Net more limited package*
Massachusetts	*MassHealth*	*Long term unemployed adults with incomes below 100% FPL*	*Medicaid package*
New York	*The Partnership Plan*	*Adults without children with incomes below 100% FPL*	*Medicaid package*
Oregon	*Oregon Health Plan Demonstration*	*Adults under age 65 with incomes below 100% FPL*	*Medicaid package based on Oregon Health Services Commission approved services*
Tennessee	*TennCare*	*Adults with incomes below 200% FPL*	*Medicaid package – all services must be "medically necessary"*
Utah	*HealthPrint*	*Adults, 19-64, with no health coverage for at least 6 months, whose employer pays less than 50% of health care benefit, with incomes below 150% FPL*	*Primary, preventive care, emergency services, lab, X-ray, pharmacy; outpatient/inpatient hospital care not covered*

HIFA Section 1115 Waiver: The HIFA Section 1115 Waiver facilitates statewide approach to increasing health insurance coverage. The Robert Wood Johnson Foundation describes the HIFA waiver as follows:

> *The Health Insurance Flexibility and Accountability Initiative (HIFA) is a Medicaid and SCHIP 1115 demonstration waiver approach that was introduced in August 2001. Its primary goal is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. It emphasizes broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the Federal poverty level. Within certain parameters, states are provided flexibility to determine their own approaches in exchange for demonstrating increased health insurance coverage in the State.*

[15] Only programs that target GAMP-type populations, i.e. adults without children, are included in this listing. Several of the listed programs also serve other target populations.

As of March 2004, nine states had obtained HIFA Section 1115 waivers. Of these, five states are using the waiver to expand coverage for uninsured single adults. Those states are Arizona, Maine, Michigan, New Mexico, and Oregon.[16]

States' Waiver Innovations
Medicaid waivers (Section 1115, HIFA, and, to a lesser extent, Section 1931) have been used by thirteen states to expand Medicaid coverage to single adults (non-parents) and to significantly enhance coverage for parents and children. A 2002 Discussion Paper issued by the Urban Institute classifies states into four classes of innovation, reflecting the extent to which states have utilized available waiver tools to increase health coverage.[17]

[16] HIFA Section 1115 Waiver, State Coverage Matrix, State Coverage Initiatives, The Robert Wood Johnson Foundation, Academy Health, Washington, D.C.
[17] Holahan, John and Mary Beth Pohl, "States as Innovators in Low-Income Health Coverage," Assessing the New Federalism, Discussion Paper, June 2002.

Appendix Table 5: States by Grouping with Current Eligibility Levels (Percent of Federal Poverty Level) for Children, Parents and Non-parents[18]

	Children	Parents	Non-parents	Expansion Type
Group 1				
Arizona	200 FPL	200 FPL	100 FPL	115/HIFA
Connecticut	300	150	--	1931
Delaware	200	100	100	115
Hawaii	200	200	100	1115
Massachusetts	200	200	133	1115
Minnesota	275	275	175	SCHIP 1115
New Jersey	350	200	100	SCHIP 1115
New York	250	150	100	1115
Oregon	170	100	100	1115/SF
Rhode Island	250	185	--	SCHIP 1115
Tennessee	400	400	400	1115
Vermont	300	185	150	1115
Washington	250	200	200	SF
Group II				
California	250	100	--	1931
Georgia	235	64	--	--
Maine	200	150	--	1931
Maryland	300	44	--	--
Missouri	300	100,125	--	1115
New Hampshire	300	64	--	--
New Mexico	235	60	--	--
Ohio	200	100	--	1931
Pennsylvania	235	68	--	--
Utah	200	150	150	HIFA
Wisconsin	185	185	--	SCHIP 1115
Group III				
Alabama	200	31	--	--
Alaska	200	82	--	--
Arkansas	200	22	--	--
Florida	200	33	--	--
Indiana	200	32	--	--
Iowa	200	90	--	--
Kansas	200	42	--	--
Michigan	200	66	--	--
Mississippi	200	39	--	--
Nevada	200	59	--	--
North Carolina	200	64	--	--
South Dakota	200	68	--	--
Texas	200	34	--	--
Virginia	200	32	--	--
Group IV				
Colorado	185	43	--	--
Idaho	150	35	--	--
Illinois	185	58	--	--
Kentucky	200	52	--	--
Louisiana	200	22	--	--
Montana	150	71	--	--
Nebraska	185	45	--	--
North Dakota	140	89	--	--
Oklahoma	185	50	--	--
South Carolina	150	56	--	--
West Virginia	150	46	--	--
Wyoming	133	67	--	--

[18] Holahan, John and Mary Beth Pohl. "States as Innovators in Low-Income Health Coverage: Assessing the New Federalism." Urban Institute Discussion Paper. June 2002.

The Urban Institute authors state:

> *We regard Group I states as the real innovators, those that have gone significantly beyond required minimums. The classification approach is based on first, whether the state extends coverage to non-parents, and second, the extent of coverage to parents and children. We argue that coverage of non-parents to 100 percent of FPL or more is the most significant step for three reasons: first, state must either obtain a Section 1115 waiver to receive FFP (federal financial participation) or solely use state funds; second, coverage of non-parents is not as politically popular as coverage of children and their parents; and third, there are many more uninsured non-parents than parents and they tend to be more costly on a per-person basis because they are generally older and less likely to be in excellent or good health.*[19]

Wisconsin, along with ten other states, is in Group II, states which have expanded coverage for children and/or parents. BadgerCare, Wisconsin's program for children and families up to 185% FPL, puts the state into the Group II category. So far, Wisconsin has not used Medicaid waivers to expand coverage beyond children and parents to single adults (non-parents). Group I states have used a variety of complex financing strategies to expand health care coverage to single adults. Following are three examples for consideration.

[19] Holahan and Pohl, p. 12.

New York: Coverage for low-income people – children, parents, and single adults (non-parents) – has been significantly expanded using a combination of Medicaid waivers and SCHIP (State Child Health Insurance Program). New York's SCHIP program was expanded in 1999 to cover children at 250% FPL. In 1997, the state obtained a Section 1115 waiver to convert its Home Relief Program (General Assistance Medical) to a program eligible for Medicaid matching funds. The state also developed "Healthy New York", an insurance program for small businesses and working poor that essentially shifts high-risk/high-cost cases to the state, thereby making insurance purchase more feasible. The following tables (New York, Massachusetts, and Oregon) from the Urban Institute report depict alternative financing strategies for health expansion.[20]

Appendix Table 6: New York Health Expansion Program

New York's Family Health Plus
Family Income as a Percentage of FPL

	Children				Parents	Nonparents
	Infants	*Age 0-5*	*Age 6-16*	*Age 17 and 18*		
Traditional Medicaid	185%	133%	100%	AFDC, ~51%	TANF	□
SCHIP-Medicaid	□	□	□	100%	□	□
SCHIP-SSP	250%	250%	250%	250%	□	□
1931 Authority	□	□	□	□	150%	□
1115 Waiver	□	□	□	□	□	100%
Premiums	<160%: None; 160-222%: $9/child/month ($27 family max); 223-250%: $15/child/month ($45 family max).[20]				None	None
Cost Sharing	None				None	None

[20] Holahan and Pohl, June 2002.

Massachusetts: The state has a variety of "products" for low income individuals and families that combine resources available through Section 1115 waiver and SCHIP with employer and worker investment. MassHealth includes five different program components; the most germane to Milwaukee County's experience are MassHealth Family Assistance and MassHealth Basic. MassHealth Family Assistance covers workers for qualified employers, using state FFP to partner with small businesses in purchasing health insurance for workers up to 200% FPL. MassHealth Basic is exclusively for single adults (non-parents) with incomes below 133% FPL who are chronically unemployed.

Appendix Table 7: Massachusetts Health Expansion Program

MassHealth Standard, Family Assistance, and Basic
Family Income as a Percentage of FPL

	Children			Parents	Nonparents	Pregnant Women
	Infants	*Age 1-16*	*Age 17 and 18*			
Traditional Medicaid	185%	133%	AFDC, ~86%	TANF	□	185%
SCHIP-Medicaid	□	150%	150%	□	□	200%
SCHIP-SSP	200%	200%	200%	□	□	□
MassHealth Family Assistance[a]	□	□	□	200%[c]	200%[c]	□
MassHealth Basic[b]	□	□	□	□	133%	□
Type of Coverage	Medicaid and SCHIP: MassHealth (Medicaid Managed Care); MassHealth Family Assistance: State-approved ESI; MassHealth Basic: Reduced benefit package, adult day and foster care, hospice, nursing facility, and non-emergency transportation services are not covered.					
Premiums	Medicaid:None; SCHIP: $10 per month for each child, family maximum of $30 per month; MassHealth Family Assistance: Any cost not paid by their employer and the state; MassHealth Basic: None.					
Cost Sharing	Medicaid and SCHIP: None; MassHealth Family Assistance: Any cost not paid by their employer and the state; MassHealth Basic: None.					

Notes: The state receives the Medicaid FFP for MassHealth Family Assistance and MassHealth Basic enrollees.

a. Childless adults must work for a qualified employer. To be qualified, an employer must: 1) have 50 or fewer employees, 2) contribute at least half the cost of the health insurance premium for benchmark coverage, 3) purchase health insurance from an approved billing and enrollment intermediary, 4) participate in the Insurance Partnership, a financial incentive program to encourage small businesses to offer health insurance to their employees. Self-employed individuals can also meet the requirements to become qualified employers. MassHealth Family Assistance is also available to children in families under 200 percent of FPL who do not meet SCHIP requirement or whose family has access to state-approved ESI.

b. Mass Health Basic is available only to chronically unemployed individuals.

c. Parents and nonparents not eligible for MassHealth Family Assistance are eligible for the state program for the uninsured.

Oregon: Oregon is known nationally as the state that tackled the tough issue of health care 'rationing'. The Oregon Health Plan, established in 1994 with a Section 1115 waiver, expanded health coverage to parents and non-parents (single adults) with incomes up to 100% FPL. To accomplish this, the state organized a process to establish service priorities, basically a list of approved services that would be paid for by the Health Plan. The fundamental idea was to limit the scope of services in order to serve a greater number of people. In 1997, Oregon developed the Family Health Insurance Assistance Program, an insurance subsidy for low-income families up to 170% FPL who purchase insurance through employers. As of 2002, Oregon was contemplating further expansion of the covered population along with further reductions in services. A recent analysis suggests that the Oregon Health Plan has suffered substantial difficulty as a result of unexpected economic, fiscal, and political pressures.[21]

Appendix Table 8: Oregon Health Expansion Plan

The Oregon Health Plan and The Family Health Insurance Assistance Program
Family Income as a Percentage of FPL

	Children		Parents	Nonparents
	Age 0-6	*Age 6-18*		
Traditional Medicaid	133%	100%	TANF, ~78%	□
Medicaid Waiver	□	□	100%	100%
SCHIP-SSP	170%	170%	□	□
FHIAP	□	□	170%	170%
Premiums	None		Traditional Medicaid and pregnant women: none; Other Medicaid: $6-$28 monthly premiums; FHIAP: 5-30% of the employee share of the premium cost.	
Cost Sharing	None		None	

[21] Oberlander, Jonathon, "Health Reform Interrupted: The Unraveling of the Oregon Health Plan & Limits of Federalism," Paper prepared for delivery at the Association for Public Policy Analysis and Management 27th Annual Fall Research Conference, Washington, D.C. November 3-5, 2005.

Effectiveness of Waivers
Section 1115 waivers allow states to try out strategies to increase health care coverage. Of most interest to GAMP is the extent to which waivers have been used to expand Medicaid services to adults without children. Although several states have used waivers, there is increasing evidence that states find waiver-based programs difficult to launch and, because waivers must be budget neutral, hard to sustain without reducing benefits.[22]

States that have aggressively pursued Medicaid waivers to expand health coverage share certain characteristics: higher per capita income, lower poverty rates, higher percentage of college educated, more urban, and more politically liberal. Even though these states seem to have the political will to expand coverage, their ability to do so is limited because of the relative inflexibility of the Medicaid program and the inability to obtain savings by rearranging existing Medicaid services in order to expand coverage to a broader population. Increasing Medicaid matching rates and allowing states more flexibility in designing health coverage programs, similar to the strategy used by SCHIP, could generate greater coverage for the hardest to cover population – uninsured single adults (non-parents).

Local (Metropolitan Level) Indigent Care Innovations

Although indigent health care is generally a state-level responsibility, local governments play an essential role. Increasingly, the pressure for innovation is coming from city and county governments stressed by the health care needs of growing numbers of uninsured workers and their families.

Three local (metropolitan level) indigent care innovations are examined in this section: California Medical Services Program, the Detroit, Michigan plan, and the Genesee (Michigan) Health Plan.

California Medical Services Program: The California Medical Services Program (CMSP) is a locally funded indigent health care program that currently involves thirty-four rural counties. The program is entirely locally funded from vehicle license fees and sales tax. No state or federal funding is utilized.

The program's governing board which was established by state statute in 1995 is comprised of eleven members, ten of whom are representatives elected by the counties and one non-voting representative from the State Health and Human Services Department. Members include three county supervisors, three county administrative officers, two county health directors and two county welfare directors. The CMSP governing board is essentially a state-created "authority" charged with the responsibility of managing indigent health care in the member counties.

The CMSP governing board has broad authority to establish eligibility and program benefits. There is an eligibility committee and a planning and benefits committee, each comprised of twelve members, including a governing representative, representatives of CMSP counties, and provider and public interest organizations. Changes in program eligibility or benefits require public hearings; however, the governing board is the final authority.

The program is available to individuals ages 21 – 64 with incomes below 200% FPL, who are not eligible for Medi-Cal benefits. At this point, the program serves 45,000-60,000 individuals monthly through an open system, i.e. patient presents a CMSP card to providers who then bill the program. Eighty percent of participants have their care fully paid for; another 15% cost-share through co-pays at the point of service.

CMSP provides health care services that parallel the state Medi-Cal program including primary and specialty care, inpatient care, inpatient mental health, pharmacy, optical, and dental. Currently the program is moving to third party administration through Blue Cross of California and plans to institute several changes including a more defined service network, tighter controls on services, and modifications of benefits. More intensive inpatient utilization management and chronic disease management initiatives, focusing on diabetes and congestive heart failure in particular, are planned as well.

[22]Kaiser Commission on Key Facts, "Medicaid Section 1115 Waivers: Current Issues," Medicaid and the Uninsured, Kaiser Commission on Key Facts, January 2005.

Detroit, Michigan Plan: This plan is part of the State of Michigan's Access to Health Care Coalition, an effort launched in 1999 and strongly supported by Governor Jennifer Granholm, to examine and address the health care needs of the uninsured population. The state level initiative generated four recommendations: 1. Maximize federal funding and increase future funding levels for Michigan services to the uninsured; 2. Stabilize safety net providers; 3. Increase information on available resources; and 4. Promote longer-term planning in Michigan. [23] The Detroit initiative fits within this context. At the governor's behest, the State of Michigan, Wayne County and the City of Detroit developed the Detroit Wayne County Health Authority (DWCHA).

DWCHA has embarked on a series of activities to significantly enhance services to the uninsured including:

- Identification of $76.5 million in additional federal matching dollars through an increase in the State's Quality Assurance Assessment Program;
- Obtaining $1 million in foundation and federal grants to support infrastructure development;
- Additional applications for Federal Qualified Health Centers and FQHC look-alikes;
- Plan to establish a primary care capital corporation to provide loan funding for facility expansions; and
- Plan to enhance the safety net services network, emphasizes primary and preventive care and care coordination.

Genesee County, Michigan: Genesee County, home of Flint, Michigan, utilized the climate for change established by the statewide initiative, Access to Health Care Coalition, to develop a new health care program for uninsured people. The Genesee Health Plan was launched with funding from the Health Resources and Services Administration of the U.S. DHHS. The plan provides two levels of care – one for very low income people (up to 35% of the federal poverty level) and a second plan with participant contributions for people with incomes between 35% and 150% of the FPL. In addition, the plan provides case management services, prescription drug assistance (with a reliance on manufacturers' programs for indigent customers), and health education and outreach.

Literature Review Themes

1. **While the indigent care problem is local, the best tools to address the problem are those available at the state and federal levels**. Cities that have effectively addressed indigent health care needs are in states that have used every available tool to fund indigent care.
2. **Successful states have 'reframed' the issue of indigent health care**. Indigent health care is seen as part of a broader approach to health care for low-income, uninsured citizens that includes 'insurance products' for low-income workers. Categorical approaches are being replaced by linked or integrated programs.
3. **Wisconsin *may* have opportunities to increase funding for indigent care** through 1115 and HIFA waivers, increased DSH, and collaboration with the private sector on small business and low-income worker insurance products.

Promising Practices in Indigent Health Care

Georgia Indigent Care Trust Fund: The Georgia Indigent Care Trust Fund is a statewide program established by state statute in 1990 as part of the state's Medical Assistance budget. Funding for the Trust Fund is re-appropriated each budget cycle and the program is administered by the Georgia Department of Community Health. The Trust Fund has three primary goals: 1) expand Medicaid eligibility and benefits; 2) support providers that serve medically indigent patients; and 3) support the growth and maintenance of primary care programs throughout Georgia.

[23] Access to Health Care Coalition, "Closing the Gap: Improving Access to Health Care in Michigan, May 2004 Update.

The Georgia Indigent Care Trust Fund consolidates funding from a variety of sources into a single funding entity for indigent care. Sources include nursing home provider fees, ambulance licensure fees, breast cancer license plate fees, Intergovernmental Transfers (IGT), Certificate of Need noncompliance fines, and Medicaid DSH (Disproportionate Share Hospital) funds. After revenues are received into the Trust Fund, annual allocations are made. In 2004, the Trust Fund distributed $731.4 million in the following manner: hospitals received 58%, nursing homes 33%, Medicaid expansion 8%, and new initiatives focusing on access to care 1%.

Trust Fund regulations initially required that hospitals allocate 15% of their gross DSH payment to primary care with 74% allocated to projects recommended by the state and 26% reserved for hospital-generated projects. In 2005, this regulation was amended to 15% of net DSH and in 2006, the federal Center for Medicare and Medicaid Services disallowed the 15% requirement altogether.

An evaluation of the Georgia Indigent Care Trust Fund conducted by the Georgia Health Policy Center reported the following findings: improved access to primary care resulting from the mandatory 15% DSH set-aside, improved coordination between primary care programs and public health, and increased public willingness to utilize revenues from a variety of health-related funding sources to support the Trust Fund. Moreover, the Trust Fund broadened responsibility for indigent health care, making indigent care a state rather than a local responsibility. In 2006, a new DSH Hospital Advisory Committee was formed to address Trust Fund allocation issues. As a result, a revised DSH allocation formula was established which improved the level of compensation for non-rural and high uncompensated care hospitals. The Georgia Trust Fund, because it represents a dedicated statewide fund involving multiple funding sources is an important model to consider in the process of examining financial and allocation options for Milwaukee and Wisconsin in the future.

Michigan Health Access Initiatives: The State of Michigan has three major initiatives that warrant examination by the Health Care Policy Task Force. These include: 1) Michigan State Planning Project for the Uninsured; 2) Adult Benefit Waiver (HIFA 1115); and 3) County Health Plans.
The Michigan Planning Project for the Uninsured was supported by a one-year HRSA (Health Resources and Services Administration) grant. (Similar grants have been used by states across the country to create statewide indigent care plans.) In Michigan, grant funds were used to establish an Advisory Council with three staffed workgroups organized around the initiative's overarching goal: *All residents have access to health insurance*. The Advisory Council focused on three strategic themes: 1) improving business competitiveness by making health care more affordable to businesses and workers; 2) maximizing the use of federal dollars; and 3) emphasizing employer-based insurance while minimizing the potential of "crowd out" of private insurance by publicly-funded health programs. The Michigan Project is significant because it represents a statewide initiative supported at the highest level (Governor's Office) focused on strategies to weave together private insurance and public benefit programs to achieve 100% coverage of the state's population.

The **Adult Benefit Waiver** is a HIFA 1115 waiver that expanded health care coverage to childless adults (ages 21 to 64) who are not Title 19 eligible or otherwise insured. The waiver is the result of a U.S. Department of Health and Human Services program called the Health Insurance Flexibility and Accountability Demonstration Initiative which was established in 2001. A description of the initiative taken from a National Conference of State Legislatures briefing states:

> *The purpose of the initiative is to expand health insurance coverage to the uninsured within currently available Medicaid and State Children's Health Insurance Program (SCHIP) resources. The initiative is targeted to people below 200 percent of poverty and offers states new flexibility in Medicaid and SCHIP. The waiver encourages statewide reforms to coordinate private and public health insurance coverage and provides for less restrictive rules regarding cost sharing and benefits design. The initiative is an 1115 waiver of Medicaid and SCHIP, which allows states to waive certain requirements of the laws to experiment with new ideas for improving the programs.*

> *The waiver gives states new flexibility to alter their usual Medicaid benefit package for optional and expansion population. The benefits package at a minimum must include basic services such as inpatient and outpatient hospital visits, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care, and age appropriate immunizations. States can alter the benefit package by putting upper limits on utilization or eliminating certain optional services, such as prescription drug services, chiropractic services, prosthetic devices, hospice or home health care services for individuals who do not need nursing home care.*
>
> *States have a great deal of flexibility for adults in premium assistance programs. CMS (Center for Medicare and Medicaid Services) does not require documentation of benefits for this population. However, states must document that children covered under a premium assistance program are receiving benefits that compare to a benchmark established for optional populations.*
>
> *Currently, the majority of Medicaid spending (65%) is for optional eligibility groups and optional benefits. Only 35% of Medicaid spending is for mandatory services for mandatory groups. (Emphasis added)*[24]

Michigan has opted to use the HIFA 1115 waiver to provide limited ambulatory care to adults without children using the state's unspent SCHIP allocation. Services include: emergency department services, lab & x-ray, limited medical supplies and durable equipment, mental health services, outpatient hospital services (diagnosis and treatment), pharmacy, physician, nurse practitioner, and clinic services, and urgent care. Inpatient services were initially included in the waiver but coverage for this benefit ended in 2005. Eligibility is limited to individuals without children with incomes below 35% of the federal poverty level after deductions for work and child care expenses. Enrollment in the program is capped at 62,000 participants.

[24] Laura Tobler, "Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative, National Conference of State Legislatures, 2007.

Appendix Table 9: Michigan Adult Benefit Waiver Services

Service	Coverage under Adult Benefit Waiver
Ambulance	*Limited to emergency group transport to the hospital Emergency Department (ED)*
Dental	*Not covered except for services of an oral surgeon as covered under the current Medicaid physician benefit for the relief of pain or infection*
Emergency Department	*Covered per current Medicaid policy. CHP members may need to get prior authorization (PA) for non-emergency services provided in the ED*
Family Planning	*Covered: Services may be provided through referral to local Title X designated family planning program*
Lab & X-ray	*Covered if ordered by an MD, DO or NP for diagnostic and treatment purposes. PA may be required by the CHP.*
Medical Supplies/Durable Medical Equipment (DME)	*Limited Coverage:* • *Medical supplies are covered except for the following non-covered categories: gradient surgical garments, formulas and feeding supplies and supplies related to any non-covered DME item.* • *DME items are non-covered except for glucose monitors.*
Mental Health Services	*Covered: Services must be provided through the PIHP/CMHSP*
Outpatient Hospital (Non-ED)	*Covered: Diagnostic and treatment services and diabetes education services. PA may be required by the CHP* *Non-covered: Therapies, labor room and partial hospitalization*
Pharmacy	*Covered:* • *Included on the Michigan Pharmaceutical Products List (except enteral formulas) that are prescribed by an MD, DO NP or type 10-enrolled oral surgeon. PA may be required by the CHP.* • *Psychotropic medications are provided under the FFS benefit for all ABW beneficiaries (FFA and CHP).* *Non-covered: Injectables used in clinics or physician offices except for select psychotropics.*

Physician, Nurse Practitioner (NP), Oral Surgeon, Medical Clinic	*Covered:* • *Annual physical exam (including pelvic and breast exam and Pap test). Women covered under the Breast and Cervical Cancer Program may be referred to that program as appropriate.* • *Diagnostic and treatment services. May be referred to a local health department as appropriate.* • *General ophthalmologic services* • *Immunizations (except travel immunizations) May be referred to a local health department as appropriate.* • *Injections administered in a physician's office per current Medicaid policy. PA may be required by the CHP.* *Non-covered: Services provided in an inpatient hospital setting.*
Substance Abuse	*Covered through the Substance Abuse Coordinating Agencies*
Therapies	*Occupational, physical and speech therapy evaluations are covered when provided by physicians or in the hospital outpatient setting. Therapy services not covered in any setting.*
Urgent Care Clinic	*Professional services provided in a freestanding facility are covered. PA may be required by the CHP.*
Services that are not identified above are not covered under the Adult Benefit Waiver.	
Inpatient hospital services were initially covered under the waiver; however, coverage was ended March 1, 2005. Some services have co-pays.	

The Adult Benefit Waiver provided Michigan's counties with another tool for providing health care to very low income individuals. Between January 2004 and September 2005, the program served 147,875 individuals primarily through County Health Plans (67 counties) although in sixteen counties the program operated on a fee for service basis. The HIFA reached a diverse yet largely urban population and demonstrated the potential for using the 1115 waiver to reach extremely underserved populations.

Michigan has a fairly comprehensive network of **County Health Plans**; in fact, 67 of the state's 83 counties have health plans in place which are the equivalent of Milwaukee County's General Assistance Medical Program. Benefits are very basic: ambulatory care and generic drugs. Inpatient services are not covered. Services are supported by DSH, Adult Benefit Waiver, and local revenue.

The Genesee (County) Health Plan is one of Michigan's most established county health plans. Established in 2001, the Genesee Health Plan has 21,000 participants (57% of the county's uninsured population) and a $19 million annual budget comprised of Adult Benefit Waiver funds, DSH, and substantial private foundation funding. (In 2006, the Charles Stewart Mott Foundation granted $1.2 million to the health plan.) The Genesee Health Plan is an independent nonprofit (501 (c) 3) with its own governing board. The Health Plan contracts with HealthPlus of Michigan to provide member services, claims payment and pharmacy management while the County Health Department provides outreach, community education, and enrollment services.

The Genesee Health Plan has three components: 1) Adult Benefit Waiver, financed by the State of Michigan's HIFA 1115 waiver, which provides basic health care for uninsured adults at or below 35% of the federal poverty level and also provides gap coverage for people who are T19 eligible; 2) Plan B, financed with state and federal DSH payments, which provides primary care, outpatient lab and radiology, pharmacy, inpatient care, and case management for special needs for uninsured adults up to 175% of the federal poverty level; and 3) Tri-Share which is a health insurance cost-sharing plan in which the worker, employer and Genesee Health Plan each pays a third of the premium. The funding system for Part B is shown below.

The Genesee Health Plan is notable for the degree of community support it receives. In 2006, the Charles Stewart Mott Foundation, based in Flint, Michigan, the Genesee County seat, made a $1.2 million donation to the Plan. Further, in November 2006, County residents approved raising property taxes to provide additional revenue for the Health Plan.

MassHealth +
Massachusetts has received national attention for its efforts to expand health coverage to all of the state's residents. The expansion plan is based on an 1115 waiver that was obtained in 1997 to establish MassHealth. This waiver expanded Medicaid coverage to an additional 300,000 people by creating new categories of eligible populations, e.g. 18-year olds, persons with HIV/AIDS, and by expanding income limits, requiring enrollment of all Medicaid eligibles, mandating managed care plans, establishing the Insurance Partnership Program, and increasing payments to safety net hospitals. The success of the program was almost immediately apparent with an 86% reduction in "free care" charges reported by hospitals in the state.

A second 1115 waiver was approved by CMS effective July 1, 2006 which created a Safety Net Care Pool similar to those established in California, Iowa, and Florida and instituted several other key changes, including: compensation for providers on documented costs up to an annual cap (estimated to be $385 million annually), incorporation of DSH payments into the Safety Net Care Pool, improved control and ability to project expenditures, increased flexibility relative to how Medicaid funding is spent in the state.

In 2006, the Massachusetts Legislature passed the Massachusetts Health Insurance Reform Bill. Established with virtually unanimous support (154-2 in House and 37-0 in Senate), the bill requires every Massachusetts resident to purchase health insurance by July 1, 2007, imposes a penalty of the loss of state tax refund equal to 50% of an affordable health insurance premium, and creates the Commonwealth Care Health Insurance Connector to provide affordable insurance options to the uninsured. The insurance initiative breaks down the uninsured population into three categories: 1) Persons at or below 100% of the federal poverty level (FPL) would be enrolled in Medicaid (estimated at 100,000 people); 2) Persons between 100% and 300% of FPL would be provided with premium assistance on a sliding scale (estimated at 150,000 people); and 3) persons at or above 300% of FPL would be offered affordable private insurance (estimated at 204,000 people).

The Massachusetts model is one of the country's most ambitious although other states including California and Wisconsin have announced similar efforts. Massachusetts' strategic use of the 1115 waiver and its willingness to encourage the health insurance industry to create and market more affordable health insurance products provide a model for potential replication.

Reference List

Access to Health Care Coalition, "Closing the Gap: Improving Access to Health Care in Michigan," May 2004 Update.

Bruen, Brian K. and Joshua M. Wiener, "Recent Changes in Health Policy for Low-Income People in Wisconsin," Assessing the New Federalism, The Urban Institute, State Update No. 25, March 2002.

Bruen, Brian K. and John Holahan, "Acceleration of Medicaid Spending Reflects Mounting Pressures," Kaiser Commission on Medicaid and the Uninsured, May 2002.

Coughlin, Teresa A. and David Liska, "Changing State and Federal Payment Policies for Medicaid Disproportionate-Share Hospitals," Health Affairs, Volume 17, Number 3, May/June 1998.

Gallagher, L. Jerome, Cori E. Uccello, Alicia B. Pierce, Erin B. Reidy, "State General Assistance Programs," Assessing the New Federalism, The Urban Institute, April 1999.

Holahan, John and Mary Beth Pohl, "States as Innovators in Low-Income Health Care Coverage," Assessing the New Federalism, Discussion Papers, Urban Institute, June 2002.

Kaiser Commission on Key Facts, "Medicaid Section 1115 Waivers: Current Issues," Medicaid and the Uninsured, Kaiser Commission on Key Facts, January 2005.

Mechanic, Robert E., "Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments," National Health Policy Forum, The George Washington University, Washington, D.C. September 14, 2004.

Oberlander, Jonathon, "Health Reform Interrupted: The Unraveling of the Oregon Health Plan & Limits of Federalism," Paper prepared for delivery at the Association for Public Policy Analysis and Management 27th Annual Fall Research Conference, Washington, D.C., November 3-5, 2005.

Silow-Carroll, Sharon and Tanya Alteras, "Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds," Economic and Social Research Institute, Commonwealth Fund, October 2004.

Wynn, Barbara, Theresa Coughlin, Sherhiy Bondarenko, and Brian Bruen, "Analysis of the Joint Distribution of Disproportionate Share Payments," PM-1387-ASPE, Prepared for the Assistant Secretary of Planning and Evaluation, Department of Health and Human Services by RAND, September 20, 2002.